DMERC

Medicare

News

DMERC A Service Office ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800 ◆ Phone 866-419-9458 ◆ www.umd.nycpic.com
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IMPORTANT NOTICE TO SUPPLIERS

Changes to DMERC A Publications for Fiscal Year 2003

For fiscal year 2003 (FY03), the Centers for Medicare & Medicaid Services (CMS) have given a specified maximum budget for each contractor's level of effort used to provide educational services. The Region A Durable Medical Equipment Regional Carrier (DMERC A) is changing its publication processes to make the most of the available funding; most notably, as related to the Program Safeguard Contractor (PSC).

As previously published in the *DMERC Medicare News*, CMS awarded a Medicare Program Safeguard Task Order to TriCenturion, LLC. As the PSC for Region A, TriCenturion assumed responsibility for medical policy development, medical review, and benefit integrity for Region A durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims. TriCenturion maintains a Web site at *www.tricenturion.com*. The PSC Web site contains information on:

- Fraud and Abuse
- Healthcare Common Procedure Coding System (HCPCS)
- Local Medical Review Policies (LMRPs) [draft and final]

Updates and changes involving the above topics will no longer be published in the quarterly bulletins, nor posted to our Web site at *www.umd.nycpic.com*. Instead, suppliers should visit the PSC Web site to access this information directly from the PSC. Suppliers should continue to visit the DMERC A Web site for information regarding billing, educational updates and events, electronic data interchange (EDI), fee schedules, what's new, etc.

Providers can obtain additional information by visiting the following CMS Web sites:

- *cms.hhs.gov/providerupdate* (CMS Quarterly Provider Update)
- *cms.hhs.gov/medicare* (Medicare Professional and Technical Information)
- *cms.hhs.gov/manuals/memos* (Program Memos)
- *cms.hhs.gov/manuals/transmittals* (Program Transmittals)
- *cms.hhs.gov/manuals/108_pim* (Medicare Program Integrity Manual)
- *cms.hhs.gov/manuals/14_car* (Medicare Carriers Manual)

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DMERC A Contacts

Supplier Toll-Free Number	866-419-9458	National Supplier Clearinghouse	866-238-9652
Beneficiary Toll-Free Number	800-842-2052	Program Education & Training	570-735-9666
Beneficiary Toll-Free Number (PA only)	800-Medicare	Program Education & Training Fax	570-735-9442
Check Control/MSP Fax	570-735-9594	Program Inquiries Fax (Hearings & Reconsiderations)	570-735-9599
EDI Fax	570-735-9510	Program Inquiries Voice Mail (Hearings)	570-735-9513
EDI Helpdesk	570-735-9429	SADMERC	877-735-1326

This bulletin should be shared with all health care practitioners and managerial members of the supplier staff. All bulletins are available at no-cost from our Web site at www.umd.nycpic.com.

Billing

Is Your National Supplier Clearinghouse (NSC) Number Currently Active?

Suppliers should periodically contact the NSC to verify that their NSC number is still active. Your NSC number can be deactivated by the NSC for several reasons. NSC numbers can be deactivated if the supplier is not regularly submitting claims to the durable medical equipment regional carriers (DMERCs). The numbers can also be deactivated if the supplier does not return the re-enrollment package to the NSC. Suppliers whose NSC numbers have been deactivated or who have decided to cancel their NSC number are no longer eligible to bill Medicare.

When providing services, it is important to ask if the services are for a Medicare beneficiary. Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare NSC number.

Therefore, any expenses for items supplied to a Medicare beneficiary on or after the effective date of the deactivation or revocation of the NSC number are the responsibility of the supplier. The beneficiary can only be held responsible for the expenses if the supplier has proof that the beneficiary was notified in accordance with section 1834(a) (18) (ii) of the Social Security Act, and the beneficiary has agreed to take financial responsibility if not covered by Medicare. The DMERC A suggests that suppliers have this statement in writing, signed and dated by the beneficiary ***prior to or*** on the day of ***rental or*** purchase. Failure to do so may result in having to refund the beneficiary in full for all services that would have been covered by Medicare. Suppliers are required to refund on a timely basis to the beneficiary and will be liable to the beneficiary for any amounts collected from the beneficiary for such items. Suppliers that fail to refund as required are subject to Civil Money Penalties under 1834(j) (4) of the Social Security Act.

If you have any further concerns regarding your supplier number, contact the NSC at **866-238-9652**.

Timely Filing Reminder

This is a reminder that the **deadline** for filing claims with dates of service **October 1, 2000 through September 30, 2001** is as follows:

- All **paper** claims filing must be received by the DMERC A no later than December 31, 2002; and
- All **electronic** claims filing must be received on our Bulletin Board System, and pass through our front-end edits, by 5:00 PM, December 31, 2002.

Suppliers are strongly encouraged to submit claims well before the above timeframes to ensure their timely receipt and avoid denial.

Medicare Secondary Payer (MSP) Reminder

If a beneficiary has primary insurance and doesn't follow the guidelines of that plan, **Medicare will pay for one service only.** For example, the primary insurance is denying because: 1. no pre-authorization; 2. services provided outside the prepaid health plan,such as out-of-network providers; 3. no referral; or 4. timely filing. If the beneficiary continues to receive services outside the primary insurance coverage guidelines, Medicare will deny susequent claims because the primary insurance guidelines are not being followed by the beneficiary.

Also, as a reminder… Please only fill in Item 29 of a HFCA-1500 form with the amount the beneficiary has paid to you. **This field is not for the primary payment amount.** If this field is populated, the beneficiary will receive all or a portion of the Medicare payment.

When submitting a primary explanation of benefits (EOB), please include an explanation of the denial codes or documentation stating why no payment is being made. If no durable medical equipment (DME) coverage or routine vision services or diabetic supplies are not covered, for example, a yearly denial letter is required.

Change Requests On the Internet

Article references can be found at these Web sites:
cms.hhs.gov/manuals/memos; or
cms.hhs.gov/manuals/transmittals.

Correction - Place of Service (POS) Code 65

An article published in the September 2002 edition of the *DMERC Medicare News* indicated that a correction would be issued regarding POS code 65. The Centers for Medicare & Medicaid Services (CMS) identified this code as a nonfacility (NF) for payment purposes. Therefore, the correct listing is:

POS Code/*Name* Description	Payment Rate	Crosswalk To
65/*End-Stage Renal Disease Treatment Facility*	**NF**	**—**

A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

[Reference: Change Request (CR) 2294; Transmittal 1765]

Correction - Claims for Medicare Beneficiaries in State or Local Custody Under a Penal Authority

This is a correction to an article published in the September 2002 edition of the *DMERC Medicare News*. **Effective April 1, 2003**, the durable medical equipment regional carriers (DMERCs) must deny claims identified by the Common Working File (CWF) as non-covered under 42 CFR 411.4(a) and 411.4(b). These non-covered charges will be adjudicated with Remark Code N103: "Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt."

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively. The Centers for Medicare & Medicaid Services (CMS) presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of the QJ modifier. A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

[Reference: Change Request (CR) 2022; Transmittal AB-02-164]

Deported Medicare Beneficiaries

Sections 226 and 226(A) of the Social Security Act (the Act) provide that no payments may be made for benefits under Part A of Title XVIII of the Act if there is no monthly benefit payable under Title II. Section 1836 of the Act limits Part B benefits to those who are either entitled to Part A benefits or who are age 65 and a United States (US) resident, US citizen or a lawfully admitted alien residing permanently in the US. Finally, a deported beneficiary is not allowed to enter the US and cannot be lawfully present in the United States to receive Medicare-covered services.

Effective April 1, 2003, the Centers for Medicare & Medicaid Services (CMS) will begin denying claims for deported beneficiaries, based on data from the Social Security Administration (SSA). A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis of deportation status.

[Reference: Change Request (CR) 2377; Transmittal AB-02-162]

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Durable Medical Equipment Ordered With Surrogate Unique Physician Identification Numbers (UPIN)

Section 1833(q) of the Social Security Act requires that all physicians who meet the Section 1861(r) definition of a physician must have a UPIN. All claims for services ordered or referred by a physician must include the name and UPIN of the ordering/referring physician.

A physician or supplier who bills Medicare for a service or item must show the name and UPIN of the ordering/referring physician on the claim form, if that service or item was the result of an order or referral from a physician. If the ordering physician is also the performing physician, the physician must enter his/her name and assigned UPIN as the ordering physician. If the ordering/referring physician is not assigned a UPIN, the biller may use a surrogate UPIN.

A physician or supplier who submits a claim for a service or item is responsible for ensuring that the name and UPIN of the ordering/referring physician is obtained and submitted on a HCFA-1500 form. Physician names and UPINs can be found in the UPIN directory. If the physician's UPIN has not yet been issued, a surrogate UPIN is to be used **only** until an individual UPIN has been assigned. Surrogate UPINs are used under these conditions:

OTH000: To be used when the ordering/referring physician has not yet been assigned and does not qualify for one of the other surrogate UPINs.

RES000: To be used by physicians meeting the description of "intern," "resident," or "fellow."

VAD000: To be used by physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs.

PHS000: To be used by physicians serving in the Public Health Service, including the Indian Health Service.

RET000: To be used by retired physicians who have not been issued a UPIN (Retired physicians who have been assigned a UPIN must use the assigned UPIN).

It is the Centers for Medicare & Medicaid's (CMS') goal to assign a UPIN to every physician/health care practitioner and group practice that meets the Medicare definition.

[Reference: Change Request (CR) 2268; Transmittal AB-02-125]

Year 2003 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder

The new HCPCS update is **effective for dates of services on or after January 1, 2003**. The 3-month grace period still applies to discontinued HCPCS codes. The grace period applies to claims received prior to April 1, 2003, which include 2002 discontinued codes for dates of service January 1, 2003 through March 31, 2003. The updated HCPCS listing is available via the Region A Program Safeguard Contractor (PSC) Web site at *www.tricenturion.com*.

[Reference: Change Request (CR) 2358, Transmittal AB-02-132]

New HCPCS Modifiers for Claims Submission

Effective for items **furnished on or after January 1, 2003**, new modifiers are to be used with Healthcare Common Procedure Coding System (HCPCS) codes for claims submission. The following outlines the changes.

An **AX** modifier is added to identify supplies and equipment furnished in conjunction with dialysis services, but are not specifically identified as dialysis supplies or equipment in the HCPCS code descriptor. Suppliers must attach the **AX** modifier to codes A4651, A4652, A4656, A4657, A4660, A4663, A4670, A4712, A4927, A4928, A4930, A4931, E1632, E1637 and E1639 when they are used to bill for dialysis supplies or equipment.

The following modifiers are added to identify supplies and equipment that may be covered under more than one durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit category:

AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

AV - Item furnished in conjunction with a prosthetic device, prosthetic or orthotic

AW - Item furnished in conjunction with a surgical dressing

BA - Item furnished in conjunction with parenteral and enteral nutrition (PEN) services

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At this point, modifier **BA**, which replaces the XA modifier, would only be used for claims for IV poles (code E0776) furnished in conjunction with parenteral and enteral nutrition (PEN) services. In addition, codes A4450 and A4452 for tape are the only codes that have been identified at this point that would require use of these modifiers, namely **AU**, **AV**, and **AW**.

For more information regarding the new modifiers, and other HCPCS coding changes for 2003, visit the Region A Program Safeguard Contractor (PSC) Web site at *www.tricenturion.com*.

[References: Change Request (CR) 2371; Transmittal AB-02-132 and Change Request (CR) 2378; Transmittal AB-02-152]

Annual Update for Skilled Nursing Facility (SNF) Consolidated Billing

Changes in designation of codes from excluded to included (or vice versa) in consolidated billing are considered corrections to align the codes with policy as opposed to changes in policy. Newly established Healthcare Common Procedure Coding System (HCPCS) codes will be added to Common Working File (CWF) edits to allow carriers to make appropriate payments in accordance with policy for SNF consolidated billing. In December 2002, new code files will be posted on the CMS Web site at *www.cms.hhs.gov/medlearn/snfcode.asp* for the corrections, which are **effective January 1, 2003**.

[Reference: Change Request (CR) 2446, Transmittal B-02-076]

Comprehensive List of HCPCS Codes Subject to Home Health Consolidated Billing - January 2003 Update

Program Memorandum (PM) Transmittal AB-02-137 (Change Request 2402, released on October 11, 2002) issued the first quarterly home health consolidated billing update for calendar year 2003. It incorporates new temporary codes, as well as the annual update of all HCPCS codes that are subject to consolidated billing. The following is the comprehensive list of codes:

A4212	A4310	A4311	A4312
A4313	A4314	A4315	A4316
A4319	A4320	A4321	A4322
A4323	A4324	A4325	A4326
A4327	A4328	A4330	A4331
A4332	A4333	A4334	A4335
A4338	A4340	A4344	A4346
A4347	A4348	A4351	A4352
A4353	A4354	A4355	A4356
A4357	A4358	A4359	A4361
A4362	A4364	A4365	A4367
A4368	A4368	A4369	A4371
A4372	A4373	A4375	A4376
A4377	A4378	A4379	A4380
A4381	A4382	A4383	A4384
A4385	A4387	A4388	A4389
A4390	A4391	A4392	A4393
A4394	A4395	A4396	A4397
A4398	A4399	A4400	A4402
A4404	A4405	A4406	A4407
A4408	A4409	A4410	A4413
A4414	A4415	A4421	A4422
A4455	A4458	A4460	A4462
A4481	A4622	A4623	A4625
A4626	A4649	A4656	A4657
A4712	A4930	A5051	A5052
A5053	A5054	A5055	A5061
A5062	A5063	A5071	A5072
A5073	A5081	A5082	A5093
A5102	A5105	A5112	A5113
A5114	A5119	A5121	A5122
A5126	A5131	A6010	A6011
A6020	A6021	A6022	A6023
A6024	A6154	A6196	A6197
A6198	A6199	A6200	A6201
A6202	A6203	A6204	A6205
A6206	A6207	A6208	A6209
A6210	A6211	A6212	A6213
A6214	A6215	A6219	A6220
A6221	A6222	A6223	A6224
A6228	A6229	A6230	A6231
A6232	A6233	A6234	A6235
A6236	A6237	A6238	A6239
A6240	A6241	A6242	A6243
A6244	A6245	A6246	A6247
A6248	A6251	A6252	A6253
A6254	A6255	A6256	A6257
A6258	A6259	A6261	A6262
A6266	A6402	A6403	A6404
A6405	A6406	A6410	A7043
A7501	A7502	A7503	A7504
A7505	A7506	A7507	A7508
A7509	K0581	K0582	K0583
K0584	K0585	K0586	K0587
K0588	K0589	K0590	K0591
K0592	K0593	K0594	K0595
K0596	K0597		

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Revised X12N 4010 837 Professional Flat File

Program Memorandum (PM) Transmittal B-02-068 (Change Request 2265, released on October 25, 2002) provides a revised X12N-based 4010 837 professional flat file for carriers, durable medical equipment regional carriers (DMERCs) and their standard systems for implementation of the Accredited Standards Committee X12N 837 professional version 4010. The flat file was updated for two reasons:

1. To allow the submission of Transmission Type Code 004010X098D in the REF Transmission Type Identification segment, element REF02.

2. To correct the example given in the DTP Date – Service Date segment, element DTP03. The "dash" from the RD8 example has been removed to avoid potential confusion.

The updated 837 4010 professional flat file is called 4010-2.zip and is posted to the following Web site: *http://cms.hhs.gov/providers/edi/hipaadoc.asp.*

So their transactions do not reject as a result of this revision, Electronic Data Interchange (EDI) submitters must enter the value "004010X098" in REF02 until April 1, 2003.

Implementation of the HIPAA Eligibility Transaction

Medicare contractors are working with the Centers for Medicare & Medicaid Services (CMS) to develop the requirements for implementing the Health Insurance Portability and Accountability Act (HIPAA) version of the Eligibility Inquiry and Response Transaction - the ANSI 270/271 version 4010. Although certain details are still being worked out, some requirements have been established.

- The 270/271 will be supported in real-time by Medicare and not in batch;
- The 270/271 implementation guide adopted for national use under HIPAA can be obtained at the Washington Publishing Co. Web site at *www.wpc-edi.com/HIPAA*;
- A provider that prefers to obtain eligibility data in an electronic data interchange (EDI) format, but that does not want to use the 270/271 version 4010, may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs;
- Provider, clearinghouse, and vendor testing is not required prior to production use, but will be conducted if requested, and there will not be a charge for such testing;
- We expect that we will be able to facilitate the testing process sometime after April 2003;
- A Direct Data Entry (DDE)/ VIPS Provider Inquiry System (VPIQ) entry access (Professional Provider Telecommunications Network (PPTN)) will be available to access eligibility data;
- The home health benefit period information is expected to be of particular interest to providers affected by home health consolidated billing, but they must use the 270/271 or PPTN (DDE/VPIQ) to obtain the HHA data elements;
- Access and changes to PPTN eligibility screens will be disseminated in a future publication;
- All other electronic formats, for the request and receipt of eligibility data will not be used after October 16, 2003; and
- Several eligibility data elements will become available as a result of this change that were not previously available through PPTN (DDE/VPIQ), or via previous versions of the 270/271.

Inquiry and Response Information (270/271)

The following data elements will be used to process an eligibility query:

HICN
Surname
First name
Date of birth
Sex
Carrier number
Provider number
Requester ID (submitter ID)
Usage indicator (Production or Test)
Applicable date
Host ID

The first three data elements must be

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entered correctly in the 270 at a minimum to enable a 271 to be generated for error reporting. Otherwise, a 997 or TA1 will be issued, as applicable.

All physicians, suppliers, and pharmacies authorized to receive eligibility data will be issued the same data set. The following information will be returned in the 271 eligibility data response as applicable:

- Carrier number
- Provider number
- Requester ID
- Date & time stamp
- Surname
- First initial
- HICN
- Zip code
- Date of birth
- Date of death
- Sex code
- Applicable date
- Current Part B entitlement date
- Current Part B termination date
- HMO ID code
- HMO option code
- HMO entitlement date
- HMO termination date
  - Other program entitlement
  - Workers compensation
  - Black lung
- MSP Data (can occur up to 5 times):
  - MSP code
  - MSP effective date
  - MSP termination date
  - MSP insurers name
  - MSP insurers address
  - MSP insurers city, state/zip
- Lifetime reserve days
- Part A Spell Data:
  - Hospital days remaining
  - Co-insurance hospital days remaining
  - SNF days remaining
  - Co-insurance days remaining
  - Inpatient deductible remaining
  - Date of earliest billing action
  - Date of latest billing action
- Part B Spell Data:
  - Most recent Part B year
  - Part B cash deductible remaining
  - Part B physical/speech therapy limit remaining
  - Part B occupational therapy limit remaining
- Hospice period number
- Hospice start date
- Hospice termination date
- Pap risk indicator
- Pap date
- Mammography risk indicator:
  - Mammography date
  - Screening risk indicator
  - Technical or professional
  - Recent dates
- Glaucoma risk indicator:
  - Technical or professional
  - Recent dates
- Colorectal risk indicator
  - Technical or professional
  - Recent dates
- Prostate risk indicator:
  - Technical or professional
  - Recent dates
- Pelvic risk indicator:
  - Technical or professional
  - Recent dates
- ESRD first code
- ESRD effective date
- Transplant indicator
- Transplant discharge date
- HHEH data (current two episodes):
  - HHEH start date
  - HHEH end date
  - HHEH date of earliest billing action
  - HHEH date of latest billing action
- HHEB Data (current two episodes):
  - HHBP start date

CWF Data Flow Documents

The following CWF data flow documents may be downloaded at:
www.cms.hhs.gov/providers/edi/edi3.asp#ELIGIBILITY
by any interested entity:

1. Detail flows of the carrier process from end to end
2. HIPAFLOW - High level view of the new 270 and ELGB process
3. Map 270/271 elements - Breakdown of all 270/271 data elements
4. Map 270 997 & TA1 - Breakdown of all 270, 997, and TA1 data elements
5. Map 271 EB 2110C - Detailed mapping of all the EB fields (CWF data being sent back on a 271 response)

[Reference: Change Request (CR) 2223, Transmittal B-02-051]

HIPAA Changes

Don't get left behind; get all the up-to-date facts on the changing Health Insurance Portability and Accountability Act (HIPAA) information on our Web site at *www.umd.nycpic.com/emc&hipaa.html.*

Remittance Advice Coding Update

Program Memorandum (PM) Transmittal AB-02-142 (Change Request 2395, released on October 18, 2002) updates remark and reason codes, which are effective January 1, 2003.

X12N 835 Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. Under the Health Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X12 recognized maintainers of those code sets, instead of proprietary codes to explain any adjustment in the payment. The list of remark codes is available at *www.cms.hhs.gov/medicare/edi/hipaadoc.asp* and *www.npc-edi.com/hipaa*, and the list is updated each March, July, and November. The following list summarizes changes made through June 30, 2002.

New Remark Codes:

Code **Current Narrative**

N113 You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.

N114 During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.

N115 This decision is based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is reasonable and necessary. A copy of this policy is available at *www.LMRP.net*.

N116 This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Modified Remark Codes:

Code **Current Narrative**

M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim either within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:
1. If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or
2. If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position.

If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If

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the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42 CFR 411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later). You may make the request through any Social Security office or through this office.

MA01 (Initial Part B determination, Medicare carrier or intermediary)—If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later, unless you have a good reason for being late.

If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.

MA02 (Initial Medicare Part A determination)—If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. Decisions made by a QIO must be appealed to that QIO within 60 days (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.).

N103 Social Security records indicate that this beneficiary was a prisoner when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law,

the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

Additionally, the following codes were modified before February 28, 2002, but were not included in Transmittal AB-02-067 (CR 1959).

Code	Current Narrative
MA49	Missing/Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50	Missing/Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51	Missing/Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA82	Did not complete or enter the correct physician/physician assistant/nurse practitioner/clinical nurse specialist/supplier's billing number/NPI and/or billing name, address, city, state, zip code, and phone number.
MA112	Our records indicate that the performing physician/physician assistant/clinical nurse specialist/certified registered nurse anesthetist/anesthesia assistant/supplier/nurse practitioner is a member of a group practice; however, you did not complete or enter accurately the group's name, address, zip code and their carrier assigned individual and group PINs.

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year at *www.wpc-edi.com/hipaa*. The committee approved the following reason code changes in June 2002.

New Reason Codes:

Code	Current Narrative
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provide contracted/negotiated rate expired or not in file
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

Modified Reason Codes:

Code	Current Narrative
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure/revenue code is inconsistent with the provider type/specialty (taxonomy).
108	Payment adjusted because rent/purchase guidelines were not met.

Implementation of ICD-9-CM Codes Using Date of Service and Not Date of Receipt - Reminder

According to the Health Insurance Portability and Accountability Act (HIPAA), national code sets must be date of service compliant. Therefore, **effective for all claims received on or after January 1, 2003**, the Region A Durable Medical Equipment Regional Carrier (DMERC A) will be verifying the validity of diagnosis codes based on the date of service of the procedure code to which the diagnosis code is correlated. For example:

1. Diagnosis code 771.8 is a valid code for dates of service prior to the release of the 2003 annual ICD-9-CM code update With the 2003 update, it becomes a truncated diagnosis because more specific five-digit codes have been created. If correlated to services performed on or after October 1, 2002, (and the claim is submitted after the 3-month grace period) the claim will be returned as unprocessable as the diagnosis was truncated at the time the service was performed.
2. Claims submitted before January 1, 2003, with dates of service October 1, 2002 through December 31, 2002, may continue to report the four-digit diagnosis code 771.8. This 3-month grace period is intended to give physicians/non-physicians sufficient time to obtain and integrate the updated 2003 ICD-9-CM codes into their billing systems. If the claim is received on or after January 1, 2003, and 771.8 is correlated to a service performed on or after October 1, 2002, the claim must be returned as unprocessable.

[Reference: Change Request (CR) 2209, Transmittal B-02-064]

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Miscellaneous

Establishment of New P.O. Boxes

Effective December 1, 2002, the Region A Durable Medical Equipment Regional Carrier (DMERC A) implemented new post office (P.O.) boxes. The purpose of the new P.O. boxes is to enhance customer service, save time on processing, and expedite payment. The following new P.O. boxes are to be utilized:

P.O. Box 1246 Specialty Claims
All other claim types not listed below

P.O. Box 599 Mobility/Support Surfaces Claims
Power Operated Vehicle (POV); Hospital Beds and Accessories; Repairs; Motorized/Power Wheelchair Base; Manual Wheelchair Base; Wheelchair Options and Accessories; Seating Systems, Back Module; Pressure Reducing Support Surfaces-Groups I, II and III; Miscellaneous Support Surfaces; Pneumatic Compression Device (for Lymphedema)

P.O. Box 587 Drugs Claims
Infusion; Immunosuppressive; Nebulizers; Oral Anti-Cancer; Oral Anti-Emetic; End Stage Renal Disease (ESRD); Epoetin (EPO)

P.O. Box 877 PEN Claims
Parenteral Nutrition; Enteral Nutrition (including E0776 and A5200)

P.O. Box 508 Oxygen Claims
Oxygen and Oxygen Equipment; Respiratory Assist Device (RAD); Continuous Positive Airway Pressure (CPAP) System; Ventilators; Cough Stimulating Device; Intrapulmonary Percussive Ventilation (IPV) System

P.O. Box 1068 Reviews

P.O. Box 450 Hearings and Administrative Law Judge Hearings (ALJs)

P.O. Box 1363 General Correspondence Inquiries

Please refer to the above to identify the types of claims, categorized by policy group, for the proper P.O. box. **NOTE: If there are several policy groups on a claim, submit the claim to the P.O. box referencing the policy group on the first claim line.**

P.O. Box 6300 will remain in effect for accounting issues (e.g., refund checks), and P.O. Box 6800 will remain in effect for all other correspondence issues. Updates to the P.O. box listing will be posted to the DMERC A Web site (*www.umd.nycpic.com*).

DMERC A's Gift Policy

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Region A Durable Medical Equipment Regional Carrier (DMERC A) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DMERC A has a zero tolerance policy regarding gifts - we cannot accept any.

If you would like to express your thanks for service you have received from DMERC A's representatives, we welcome notes or letters of appreciation in place of gifts.

Appeals of Duplicate Claims

Effective January 1, 2003, the durable medical equipment regional carriers (DMERCs) will use the following Medicare Summary Notice (MSN) and remittance messages when denying duplicate claims:

MSN 7.3 – This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate.

Remark Code N111 – This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

Duplicate items and services billed to the DMERC A will not be afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate.

[Reference: Change Request (CR) 1986, Transmittal 1773]

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Implementation of Certain Initial Determination and Appeal Provisions Within §521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000

[Editor's Note: This article was previously published on our Web site at *www.umd.nycpic.com*.]

Program Memorandum (PM) Transmittal AB-02-111 (Change Request 2251, released on July 31, 2002) provides guidance on the partial implementation of §521 of the Benefits Improvement and Protection Act (BIPA) by October 1, 2002. Section 1869 of the Social Security Act (the Act), as amended by §521 of BIPA, substantially revises the Medicare claim appeals process.

New Time Limits for Filing a Request for Appeal

Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of **all** initial determinations.

Changes to the Remittance Advice (RA)

Although the Remittance Advice (RA) codes do not identify a particular filing date for provider or supplier appeals, the codes do identify the applicable Part A and Part B filing timeframes. Changes to the RA remark codes will be included in an update to be posted at *www.wpc-edi.com/hipaa* by July 31, 2002. Therefore, physicians, suppliers, and other providers will have the opportunity to view these changes prior to the October 1, 2002 implementation date.

The following RA remark codes have been updated to reflect the changes in the filing deadlines: M25, M26, M27, MA01, and MAO2. Changes to the messages are identified in the chart below in bold typeface.

RA Remark Code	Message
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim **either within 6 months of the date of this notice, if this notice is dated September 30, 2002 or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002 or later**. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. **The law permits exceptions to the refund requirement in two cases:** 1. If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or 2. If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. **If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position.** **If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.** The law also permits you to request review at any time **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**. However, a review request that is received *continued next page...*

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more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 **The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.**

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later)**. You may make the request through any Social Security office or through this office.

MA01 (Initial Part B determination, Medicare carrier or intermediary)—If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**, unless you have a good reason for being late.

If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.

MA02 (Initial Medicare Part A determination)—If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**. Decisions made by a QIO must be appealed to that QIO within 60 days. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.)

These five codes will be revised again during the Web posting update scheduled for the last week of October 2002. At that time, the references to the Part A 60-day filing timeframe and Part B 6-month filing timeframe will be removed.

Reduction of the Amount in Controversy (AIC) Required to Request a Part B ALJ Hearing

Physicians and suppliers wishing to file appeals must satisfy the Amount in Controversy (AIC) requirement in order to obtain a Part B ALJ hearing. Like the AIC requirement for Part A ALJ hearings, the AIC requirement for Part B ALJ requests will be $100, **for initial determinations made on or after October 1, 2002**. Only an ALJ has the authority to dismiss a request for an ALJ hearing based on the AIC requirement.

The Region A DMERC Provider Communications (PCOM) Advisory Group

(formerly PETAG)

One of the primary responsibilities of Program Education & Training (PET) is to assure that suppliers are fully knowledgeable about Medicare provisions and the proper claim submission requirements. Each fiscal year, the expectations of the Centers for Medicare & Medicaid Services (CMS) relative to the educational responsibilities of PET are clearly addressed in the Region A Durable Medical Equipment Regional Carrier (DMERC A) Budget and Performance Requirements (BPRs). In conjunction with the BPRs, a Statement of Work is developed by CMS to outline DMERC initiatives established to achieve the goal of providing superior customer service while protecting the integrity and promoting the success of the Medicare Trust Fund. One of these initiatives is for the DMERC A to maintain a PCOM Advisory Group, which was referred to as the Program Education & Training Advisory Group (PETAG) in fiscal year 2002. The purpose of the PCOM Advisory Group is to provide opportunities for the supplier community to:

- Offer advice and recommendations for selection of provider education and training topics;
- Propose suggestions for dissemination methods and/or locations for educational forums; and
- Interact directly with DMERC A and CMS staff to discuss current trends and global concerns within the industry.

PCOM Advisory Group membership is open to representatives from state medical societies, state supplier associations, manufacturers, billing services, and all other appropriate supplier organizations and third party entities. Current participation includes representatives from the New York Medical Equipment Dealers Association (NYMEP), Jersey Association of Medical Equipment Suppliers (JAMES), Pennsylvania Association of Medical Suppliers (PAMS), New England Medical Equipment Dealers (NEMED) Association, Pennsylvania Orthotics & Prosthetics Society (POPS), and American Orthotics & Prosthetics Association (AOPA). Membership also includes representation from the New York and Pennsylvania medical societies and several individual provider and billing service organizations.

PCOM Advisory Group meetings occur on a quarterly basis, with location selections made to best meet the needs of the participants while staying within funding limitations. Meetings held during the 2002 fiscal year took place on October 12, 2001, and January 9, 2002, in Philadelphia, PA, and on March 13, 2002, in Scranton, PA. The first meeting for fiscal year 2003 was held on October 9, 2002, at the Adam's Mark Hotel in Philadelphia, PA. The meetings generally consist of a morning DMERC A session that includes DMERC updates/issues, an educational forum, and an open question/discussion period. Some featured topics presented at the past meetings have been data analysis information, provided by the DMERC A Data and Practice Analysis (DAPA) Team, (e.g., the top five claim denials, top five procedure codes billed, state-by-state listings of new and active providers, etc.) and its many uses by PET for educational initiatives; discussions involving CMS on issues submitted by various PCOM Advisory Group members; and "hot topic issues," such as the Health Insurance Portability and Accountability Act (HIPAA).

The DMERC A has also worked in collaboration with TriCenturion, LLC, the Program Safeguard Contractor (PSC) for Region A, to include their participation as well. Afternoon sessions have typically been held by TriCenturion with the PCOM Advisory Group members to discuss issues within the responsibility of the PSC, such as medical policies and benefit integrity initiatives. More information on the PSC can be obtained via the DMERC A Web site (*www.umd.nycpic.com*) or from the PSC Web site (*www.tricenturion.com*).

The PET Team encourages any and all interested representatives to become a member of the PCOM Advisory Group. It is important to ensure our targeted educational efforts are both meaningful and helpful to the supplier community as a whole. If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please contact the PET Team at 570-735-9666 and select Option 1. Membership is FREE. The following are the meetings

continued next page...

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scheduled for the remainder of fiscal year 2003:

Date	Location
January 8, 2003	Teleconference
April 9, 2003	Newark, NJ
July 9, 2003	Philadelphia, PA

The sites are yet to be determined and will be posted on our Web site at a later date. Members will be notified via email of the details and registration process prior to each meeting.

Check our Web site for the development of a PCOM Advisory Group page, which will feature details on upcoming meetings, online membership and registration, and meeting minutes, including the materials distributed at each meeting.

DMERC A PCOM Advisory Group Mission Statement:

- In partnership, we define effective educational forums for the Region A provider community.
- Together we will address the educational needs of providers through regular briefings, recommendations and requests from the provider community and through assessment of DMERC tracking initiatives.
- We do this with the support of the Centers for Medicare & Medicaid Services (CMS) in order to assure that providers are fully knowledgeable about Medicare provisions.

Seminars, Workshops, and Educational Partnering

The Program Education & Training (PET) Team is currently developing plans and schedules for upcoming seminars and workshops to be held throughout the Region A Durable Medical Equipment Regional Carrier (DMERC A) service area. Check the DMERC A Web site (*www.umd.nycpic.com/dmprovcaln.html*) for details and registration instructions.

In an ongoing effort to disseminate Medicare program information in the most efficient manner, PET is always looking for opportunities to establish partnerships with interested parties, for the purpose of a collaborative educational approach. If your organization is interested in having a DMERC A PET representative speak at a meeting or function, or if you would like to discuss additional educational partnering opportunities, please contact the PET Team at 570-735-9666 and select Option 1. A member of the PET Team will contact you to discuss the details of your request and what we can do to accommodate your needs.

Information Resources and Customer Service Options

To help suppliers make the most of the tools available, the Region A Durable Medical Equipment Regioanl Carrier (DMERC A) updated the Supplier Contacts listing and added some more options. Here are the highlights: [Visit *www.umd.nycpic.com/dmprovcont.html* for a complete listing.]

DMERC A Supplier Manual:

The supplier manual is a very useful tool, and should be the first stop as a resource for general information on the DMERC program. The supplier manual can be accessed via our Web site with search capabilities for ease in finding information.

DMERC A Web site:

Visit *www.umd.nycpic.com* for the latest DMERC A information and to subscribe to our ListServe.

VIPS Provider Inquiry System:

(NOTE: This option is only available for suppliers who bill electronically.) The VIPS Provider Inquiry System (VPIQ) is a subsystem of the VIPS Medicare System (VMS) that allows suppliers to obtain claim-specific information (all) and beneficiary eligibility data (participating suppliers only).

Caller Information Network:

Contact the Caller Information Network (CIN) for inquiries regarding specific claims and general information. CIN representatives can be reached at **866-419-9458**, Monday through Friday (8:00 AM-4:00 PM, Eastern Time (ET)). UPDATE: The Interactive Voice Response (IVR) system will be available for specific claim information 7:00 AM-7:00 PM (ET), when the HOST system is available. The IVR is available 24 hours a day for general information.

DMERC A Email Address:

Suppliers can submit inquiries through the form located at *www.umd.nycpic.com/contactdme.html*.

Electronic Data Interchange Helpdesk:

Inquiries regarding electronic billing issues should be directed to the Electronic Data Interchange (EDI) Helpdesk. EDI Helpdesk staff can be reached at **570-735-9429**, Monday through Friday (8:30 AM-12:00 PM & 1:00 PM-4:00 PM, ET).

Program Inquiries/Hearings Voice Mail:

Inquiries regarding the status of hearing requests should be directed to the Program Inquiries/Hearings Voice Mail at **570-735-9513 (please leave a detailed message)**.

Program Education & Training:

Contact the Program Education & Training (PET) Department for inquiries regarding targeted educational efforts on DMERC programs and provisions impacting the entire supplier community. PET staff can be reached at **570-735-9666**, Monday through Friday (8:00 AM-4:00 PM, ET).

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Claim Submission Errors for the Fourth Quarter of Fiscal Year 2002

Claim submission errors (CSEs) are errors made on a claim that would cause it to reject upon submission to the Region A Durable Medical Equipment Regional Carrier (DMERC A). As part of the Program Education & Training requirements, CSEs must be tallied and analyzed for educational purposes to reduce the CSE rate. The DMERC A Data and Practice Analysis (DAPA) Team provided PET with data related to the top ten CSEs for the fourth quarter of fiscal year 2002, which ran from July 1, 2002, to September 30, 2002. During this timeframe, there were **104,179** errors on claims submitted electronically to the DMERC A.

Suppliers should make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. The DMERC A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the below chart, and share it with your colleagues!

Claim Submission Error	Correction - Electronic	Correction - Paper	Errors
1) and 2) Other Carrier's Name and Address (OCNA) number is missing or invalid. This is used for a secondary insurance crossover. The OCNA number can be found on the DMERC A Web site at *www.umd.nycpic.com/OCNA_01-02.html.*	Enter the nine-digit OCNA number in the DA0-7 and DA0-8 records.	Enter the nine-digit OCNA number in Items 9 and 11.	10,441
3) Insured's ID number is missing or invalid. This information is required, whether Medicare is the primary or secondary insurer.	Enter the patient's Medicare Health Insurance Claim (HIC) number in the DA0-18 record.	Enter the patient's Medicare HIC number in Item 1A.	7,610
4) Diagnosis code is missing or invalid. Suppliers must provide an ICD-9-CM code number, coded to the highest level of specificity, and may enter up to four codes in priority order (e.g., primary, secondary, etc. condition).	Enter the patient's diagnosis in the EA0-32 record. Narrative diagnoses must be entered in the HA0 record.	Enter the patient's diagnosis in Item 21. Narrative diagnoses must be written on the claim form.	6,459
5) Ordering/referring physician's UPIN is missing. Contact the physician, or obtain a copy of all UPINs from the local Part B Medicare offices or via the DMERC A Web site at *www.umd.nycpic.com/dmprovinfo.html* (UPIN Directory link).	Enter the physician UPIN number in the FB1-9 record.	Enter the physician UPIN number in Item 17A.	6,384
6) Beneficiary's address is invalid.	Enter the patient's street address on the first line, and the issued to suite or the apartment, room, or floor on the second line (it must have an embedded space; e.g., APT_4) in the CA0-12, Line 2, record.	Enter the patient's complete street address on the first line in Item 5.	3,344
7) Invalid diagnosis pointer. This field cannot be blank, and it is used to relate the date of service and the procedure performed to the diagnosis. When multiple services are performed, enter the primary reference number for each service (e.g., 1, 2, 3, or 4).	Enter the diagnosis code reference number in the FA0-14 record.	Enter the diagnosis code reference number in Item 24E.	2,458
8) Service "from" and "to" dates cannot span years. [Effective January 1, 2003, the Common Working File (CWF) edits will permit service dates to span years.]	Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in the FA0-605 record. Multiple years (e.g., dates of service 12/15/01-01/14/02) must be on separate claim lines (i.e., one line for each year).	Enter the precise eight-digit date(MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,445
9) Beneficiary's zip code is invalid.	Enter the patient's precise zip code in the CA0-16 record.	Enter the patient's precise zip code on the third line in Item 5.	2,063
10) Invalid enrollment form. The Electronic Data Interchange (EDI) Department does not have a valid EDI enrollment form on file for the NSC/provider number used for billing.	Before billing electronic claims, make sure an enrollment form has been submitted to the EDI Department.	Not applicable. This onlypertains to electronic claims (BA0-205).	1,755

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Fee Schedule Update for 2003 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Per Program Memorandum (PM) Transmittal AB-02-152 (Change Request 2378, released on October 25, 2002), the 2003 fee schedules are to be implemented on January 1, 2003, for items furnished from January 1, 2003 through December 31, 2003. **Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.** The Region A Durable Medical Equipment Regional Carrier (DMERC A) posts new and updated fee schedules to our Web site at *www.umd.nycpic.com/dmfees.html*. The 2003 fee schedules should be posted approximately one week prior to the January 1, 2003 implementation date. Suppliers without Internet access can request a hardcopy version by writing to:

HealthNow New York Inc.
DMERC A
Attention: FOIA
P.O. Box 1363
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New Year's Day	Wednesday, January 1, 2003
Martin Luther King, Jr. Day	Monday, January 20, 2003
Memorial Day	Monday, May 26, 2003
Independence Day	Friday, July 4, 2003
Labor Day	Monday, September 1, 2003
Thanksgiving Day	Thursday, November 27, 2003
Day after Thanksgiving	Friday, November 28, 2003
Christmas Eve	Wednesday, December 24, 2003
Christmas Day	Thursday, December 25, 2003

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